



September 27, 2019

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1717-P (Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs)

Submitted via regulations.gov

Dear Administrator Verma:

Consumers First is a new alliance that brings together interests from consumers, children, employers, labor unions, and primary care providers working to change the fundamental economic incentives and design of the health care system. Our work is to realign the incentives and design of health care so that the system truly delivers the health and high quality care that all families across our nation deserve. Together, we are working to ensure that the nation's health care system finally fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone.

Medicare payment policy often establishes a standard that is then adopted by other payers including commercial payers and Medicaid. *Consumers First* offers these comments both to strengthen Hospital Outpatient Payment for Calendar Year 2020, and because the policy changes reflected in this comment letter represent an important step toward realigning the fundamental economic incentives in the health care system to truly meet the needs of all families, children, seniors and adults across the nation. These payment changes could catalyze the transformational change that is needed to our payment systems to drive high value care into the health care system and across health care markets in the U.S.

Consumers First appreciates the opportunity to provide comment on the Medicare Hospital Outpatient Payment System rule for 2020. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety. These comments represent the consensus views of the *Consumers First* steering committee. Some individual members of the steering committee are also submitting their own comments on the rule.

Given our focus on transforming health care payment and delivery systems to ensure the system is delivering the high value care consumers need, our comments are focused on two policies outlined in the proposed rule:

- Price Transparency
- Payment for Excepted Off-Campus Provider-Based Departments

Price Transparency

Consumers First supports the Centers for Medicare and Medicaid's (CMS) efforts to significantly increase transparency in how hospital systems set prices to make health care more affordable. As noted in the rule, the lack of price transparency is a significant factor in increasing health care costs,¹ and real transparency in the actual prices paid by purchasers is critical to engaging in cost containment.²

The rule would require hospitals to publicly display “standard charge” in two forms: gross charges (also known as “chargemaster” prices) and certain payer-specific negotiated charges. The posting of gross charges is only significant to those consumers who are uninsured or are receiving services out-of-network. The public posting of the specific rate negotiated between payers and each provider holds promise in providing actionable information to key stakeholders, including consumers, employers, workers, providers, researchers, and policymakers. Of course, to avoid the risk of unintended adverse consequences, the measures taken to enhance transparency should be carefully considered as outlined below.

Gross Charges

Hospital chargemaster prices represent the “gross charge” made by a hospital, not including any discounts offered to commercial payers. Typical chargemaster prices are completely disassociated from the actual cost of providing care.³ Although hospitals often use chargemaster as the starting point to negotiate prices with insurers, both hospitals and insurers leverage their market power in price negotiations, often leading to prices that are both highly inflated, and that do not represent high value care to consumers. A 2015 study found that large hospitals typically mark up their chargemaster prices by more than three times above the Medicare-allowable costs, with significant variation between hospitals.⁴

Chargemaster prices do not reflect what most consumers actually pay.⁵ Further, chargemasters are effectively unintelligible or even misleading to consumers as medical procedures are often listed using medical acronyms.⁶ While we do not oppose the requirement of publicly posting chargemaster prices, we do not believe this requirement alone will directly benefit consumers, nor provide meaningful information for policymakers or researchers.

Negotiated Prices

While we are skeptical of the value in posting chargemaster prices, we commend CMS for its efforts to improve price transparency in order to lower health care costs. Importantly, the pricing information that is most critical to achieve price transparency is the specific rate that is negotiated between payers and each specific provider. In addition, any publically disclosed price information should also be paired with quality information. While we understand that additional work is needed to arrive at and report on a harmonized set of quality measures, we strongly believe that it is critical to establish a standard where publically disclosed price and quality information are always paired together in order to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers.

Disclosing price and quality data could represent a bold and important step in providing meaningful transparency in the quality of care and the prices paid for hospital system care, and ultimately the health care system more broadly.⁷ While health plans are directly negotiating prices with providers, it is consumers and employers that are ultimately paying for the health care provided through insurance premiums, deductibles, and copays. The notion that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been furnished must be changed.

Some academic researchers have postulated that full disclosure of prices negotiated between hospital systems and insurers could result in higher prices as hospital systems use the public information to drive up negotiated prices.⁸ Namely, researchers have cited studies on the impact of price transparency laws on concrete prices in Denmark and gasoline prices in Australia.⁹ However, there is very little empirical evidence for researchers to analyze the impact in the United States health care market. Indeed, in the United State health care market, recent research shows that disclosing price may actually help to reduce health care costs in some markets and for some services. Researches from University of Michigan analyzed the impact of New Hampshire's healthcare price transparency website. The website unveils out-of-pocket costs for privately insured people across a range of medical procedures. Researchers found that the website saved individuals \$7.9 million and insurers \$36 million on X-rays, CT scans, and MRIs from 2007 to 2011.¹⁰

The proposed rule would require hospitals to post the payer-specific negotiated charges for 300 “shoppable” services. Of those, 70 services would be mandated by CMS and 230 would be decided upon by the hospital system. While we support the intent to provide consumers with actionable information, we urge CMS to take a different tack. Evidence suggests that health care price transparency alone has little-to-no impact on consumer behavior.¹¹ There are a number of reasons this may be the case, including difficulties in understanding even well-intended transparency information; lack of quality data against which to compare price; and the attenuation of the impact of prices on out-of-pocket costs.¹² It is also important to note that while achieving price and quality transparency among hospitals would help move transparency efforts forward, there are other critical actors in the health care system that would also need to disclose price

information to achieve full price and quality transparency across the health care system. Thus, we recommend that CMS refocus the target of its price transparency efforts from changing consumer behavior to changing the behavior of providers and payers, and to informing policymakers and regulators. Individual providers (physicians and other clinicians who direct most health care spending in the United States), however, can effectively use price and quality information to encourage patients to access lower-cost, higher-value referred providers.¹³ The same holds for employers and other payers, who can use transparent price information to drive care toward higher value providers.¹⁴ There is also evidence to suggest that high-cost providers may change their pricing behavior due to public scrutiny.¹⁵

We recommend that CMS pair all price data with available quality data. *Consumers First* strongly supports the development and use of meaningful quality data. However, lack of relevant quality data on certain services should not be used as an excuse to not move forward with price transparency for those services.

Consistent with the below strategies to mitigate unintended consequences, rather than focusing on 300 “shoppable” services (including 230 to be defined by the hospitals themselves), we recommend that CMS instead mandate transparency on a smaller, but nationally uniform set of high cost and high volume services provided in the inpatient and outpatient settings. A reasonable requirement would be the publication of 100 total services:

- 25 highest price inpatient services
- 25 highest dollar value inpatient services (defined as the product of price per service multiplied by number of services provided)
- 25 highest price outpatient services
- 25 highest dollar value outpatient services

While research is inconclusive as to whether broad public transparency of negotiated prices will drive up costs, the possibility of higher prices warrants serious consideration. To mitigate the risk of higher prices and gain more meaningful data regarding the effect of price transparency on health care costs, we recommend CMS take the following precautions:

- Pilot full public price transparency in several health care markets and conduct longitudinal studies on the impact of the policy on negotiated prices.
- Make provider- and plan-specific negotiated prices available to plan sponsors and researchers in the large group market.
- Provide negotiated prices to individuals, plan sponsors, and researchers in the small group and individual markets.
- Provide limited information to the public on negotiated prices. This could include providing statistical information including the range and distribution of privately negotiated rates between providers and health plans for each of the services identified by CMS.

To the extent CMS seeks to move forward with consumer-facing price transparency, it should ensure that it conducts robust consumer outreach and engagement to understand which services consumers most need or want increased transparency and how this information can be communicated to them in an actionable way. As part of this effort, CMS should ensure that it engages with a racially and ethnically diverse group of consumers, including consumers who have limited English proficiency and individuals with disabilities.

Just as CMS suggests, the new requirement “should be viewed in the context of the broader price transparency initiative.” In future rulemaking, we will continue to push CMS to accelerate price transparency for hospitals, insurance plans, pharmaceutical and device manufacturers, and other key sectors of the health system.

Summary of Recommendations:

- *Consumers First strongly recommends that CMS include quality data in the requirement that hospitals post payer-specific negotiated prices, with the following changes:*
 - *Refocus audience for price transparency to payers, providers, and policymakers.*
 - *Establish a nationally uniform set of prices to be published based on high cost and high dollar value services in the inpatient and outpatient settings.*
- *If CMS seeks to move forward with consumer-facing price transparency, it should conduct robust outreach and engagement, particularly to underserved and racially and ethnically diverse communities.*

Payment for Excepted Off-Campus Provider-Based Departments

Over the last decade, our nation has seen a trend of once independent physician practices have becoming affiliated with major hospital systems.¹⁶ This movement is part of a larger trend of consolidation among health systems and physicians. Consolidation, in turn, has allowed health systems to use their market power to leverage higher prices for all consumers.¹⁷ Further, the drive toward higher-cost hospital-based outpatient services has had a direct negative financial impact on Medicare beneficiaries, who pay higher copays at hospital outpatient departments (HOPDs) than they do in physician offices,¹⁸ and on Medicare expenditures, as HOPDs are paid more than twice as much as physicians paid under the Medicare physician fee schedule for the same service.¹⁹

In 2015, Congress acted to mandate that new HOPDs not on the hospital’s main campus be paid at the physician fee schedule rate. CMS followed Congress’ lead in mandating “site-neutral payments” for non-excepted HOPDs in the 2020 OPPS rule. In the current proposed rule, CMS proposes to complete the two-year phase in of site-neutral payments for OPPS services.

Although we support site-neutral payments, we are concerned about the impact of this payment change on safety net health systems which provide access to outpatient care for

many of our nation's low-income and vulnerable residents. Indeed, the rule finds that because of their larger-than-average outpatient footprint, public hospitals, major teaching hospitals, and large disproportionate share hospitals would face a disparate share of the payment cuts under the proposed rule's site-neutral payment policy.²⁰ We recommend CMS consider policy modifications to reduce the impact of the site-neutral payments on safety net health systems. This could be accomplished by providing the OPPS rate to outpatient departments located in federally designated Health Professional Shortage Areas (HPSA)s or Medically Underserved Areas (MUA)s. Use of HPSA and MUA designations would be consistent with longstanding and successful federal policies designed to enhance access to care in underserved areas.

Consumers First supports the movement to site-neutral payment for health care services as a significant way to promote greater value in health care to the extent the regulatory changes are permissible under federal law. Where CMS lacks authority to implement site-neutral payments, we urge Congress to explicitly mandate site-neutral payments per the recommendations in this letter.

Recommendation: *To reduce the incentive for hospital systems to further consolidate outpatient care and to protect patients from higher out-of-pocket costs, and to the extent permissible under federal law, we strongly recommend CMS finalize the two-year phase in of reduced payment for excepted off-campus provider-based departments while developing a mechanism to protect outpatient services at vital safety-net health systems.*

Thank you for considering the above recommendations. Please contact Shawn Gremminger, Senior Director of Federal Relations at Families USA (sgremminger@familiesusa.org) for further information.

Sincerely,

American Academy of Family Physicians
American Benefits Council
American Federation of State, County, and Municipal Employees
Families USA
First Focus on Children
Pacific Business Group on Health

¹ Federal Register, Vol. 84, No. 154, Page 39573

² *ibid.*

³ "What is a chargemaster, and what do hospital administrators need to know about it?," George Washington School of Business, <https://healthcaremba.gwu.edu/blog/chargemaster-hospital-administrators-need-know/>

⁴ Ge Bai and Gerard F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios," *Health Affairs*, Vol. 34, No. 6, (June 2015), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1414>

⁵ Harris Meyer, "Hospitals vary in publishing CMS chargemaster prices," *Modern Healthcare*, Jan. 7, 2019, <http://modernhealthcare.com/article/20190107/TRANSFORMATION04/190109931/hospitals-vary-in-publishing-cms-chargemaster-prices>

⁶ *ibid.*

⁷ The Secret of Health Care Prices: Why Transparency is in the Public Interest. California Health Care Foundation. <https://www.chcf.org/publication/secret-health-care-prices/#related-links-and-downloads>

⁸ Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (2017): 1531, doi:10.1377/hlthaff.2017.0556, and; David Cutler and Leemore Dafny, "Designing Transparency Systems for Medical Care Prices," *New England Journal of Medicine* 364 (Mar. 10, 2011): 894, doi:10.1056/NEJMp1100540.

⁹ Svend Albæk, Peter Møllgaard, and Per B. Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," *Journal of Industrial Economics* 45, no. 4 (1997): 429, econpapers.repec.org., and; David P. Byrne and Nicolas de Roos, "Learning to Coordinate: A Study in Retail Gasoline," *Amer. Economic Review* 109, no. 2 (Feb. 2019): 591, doi:10.1257/aer.20170116.

¹⁰ Kelly Gooch, "New Hampshire's price transparency website helped patients save money," *Becker's Hospital Review*, Jan. 30, 2019, <https://www.beckershospitalreview.com/finance/new-hampshire-s-price-transparency-website-helped-patients-save-money.html>

¹¹ Mehrotra, Ateev, et al., "Promise and Reality of Price Transparency," *New England Journal of Medicine*, Vol. 378, No. 14 (April 5, 2018), and;

Whaley, Christopher, et al., "Association Between Availability of Health Service Prices and Payments for These Services," *Journal of the American Medical Association*, Vol. 312, No. 16 (May 3, 2018).

¹² Austin, D. Andrew and Jane G. Gravelle, *Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector*, Congressional Research Service, Washington, D.C. (July 2007).

¹³ Carman, Kristen, et al., "Understanding an Informed Public's Views on the Role of Evidence in Making Health Care Decisions," *Health Affairs*, Vol. 35, No. 4 (April 2016); and Levinson, et al., "Not All Patients Want to Participate in Decision Making-A National Study of Public Preferences," *Journal of General Internal Medicine* (June 2005).

¹⁴ Robinson, James, and Timothy Brown, Evaluation of Reference Pricing: Final Report, letter to David Cowling of CalPERS (May 15, 2013). Available at: <https://kaiserhealthnews.files.wordpress.com/2014/05/reference-pricing-california-berkeley.pdf>.

¹⁵ Wu, Sze-jung, et al., "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition," *Health Affairs*, Vol. 33, No. 8 (August 2014).

¹⁶ Jeff Lagasse, "Hospitals acquired 5,000 physician practices in a single year," *Healthcare Finance*, March 15, 2018, <https://www.healthcarefinancenews.com/news/hospitals-acquired-5000-physician-practices-single-year>

¹⁷ Bela Gorman, Don Gorman, Jennifer Smagula, John D. Freedman, Gabriella Lockhart, Rik Ganguly, Alyssa Ursillo, Paul Crespi, and David Kadish, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, New York: New York State Health Foundation, December 2016, <https://nyshealthfoundation.org/wp-content/uploads/2017/11/an-examination-of-new-yorkhospital-reimbursement-dec-2016.pdf>

¹⁸ Federal Register, Vol. 84, No. 154, Page 39616

¹⁹ Federal Register, Vol. 84, No. 154, Page 39616

²⁰ Federal Register, Vol. 84, No. 154, Pages 39620-39623